

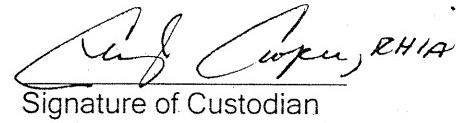
MEMORIAL HOSPITAL AT GULFPORT
CERTIFICATION BY CUSTODIAN OF MEDICAL RECORDS

STATE OF MISSISSIPPI

COUNTY OF HARRISON

The undersigned being duly sworn does state on oath as follows:

1. That she is the duly authorized custodian of the hospital medical records of MEMORIAL HOSPITAL AT GULFPORT and has the authority to certify records.
2. That the within and annexed are true and correct copies of requested portions from the medical records of MCBAY, GARY, DOB: 08/05/1976 as described in the correspondence received for these records.
3. The within and annexed records were prepared either by the personnel of the hospital or it's staff, physicians or by persons acting under the control either of them, in the ordinary course of hospital business at or near the time of the act, condition or event reported therein.



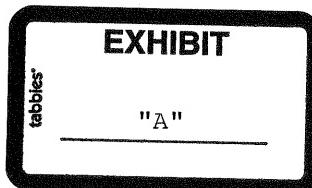
Signature of Custodian

SWORN AND SUBSCRIBED before me, this 20 day of May 2009



Notary Public

MISSISSIPPI STATEWIDE NOTARY
MY COMMISSION EXPIRES SEPT 8, 2014
BONDED THRU STEGALL NOTARY SERVICE



PHNS Inc - Hunter Account
Health Information Specialists

DUKES DUKES KEATING AND FANECA
2909 13TH ST
FL 6
GULFPORT, MS 39501-1925

Wednesday, May 20, 2009
Reference Number: MS36-2275973W

Facility: MEMORIAL HOSPITAL AT GULFPORT
4500 13TH ST
GULFPORT, MS 39501-2515
(228) 865-3044

Regarding Patient: GARY MCBAY

Dear Requestor:

Your request for medical records has been received by PHNS Inc - Hunter Account. PHNS Inc - Hunter Account has contracted with this medical facility to provide you with copies of the medical records you requested. Copies are made from the medical facility's original medical records. The confidentiality of these records is protected by federal and state law. These medical records are intended exclusively for the requested purpose and cannot be recopied or redistributed for other purposes without written informed consent of the patient.

Your request for medical records has been completed. There is a cost for providing these copies and an invoice is enclosed. Please see the attached invoice for payment details.

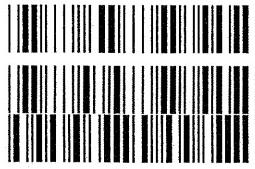
PLEASE REMIT CHECK TO:**PHNS Inc - Hunter Account**

PO BOX 671281,

Dallas, TX 75267-1281

Phone: 800-778-4839

Federal Tax ID Number: 72-1292247

**BILL TO:**

DUKES DUKES KEATING AND FANECA
 2909 13TH ST
 FL 6
 GULFPORT, MS 39501-1925

**Ship To:**

Date: 5/20/2009 9:39:33 AM	DUKES DUKES KEATING AND FANECA
Invoice#: MS36-2275973W	2909 13TH ST
Amount Due: \$0.00	FL 6 GULFPORT, MS 39501-1925

Facility Name: MEMORIAL HOSPITAL AT GULFPORT	Insured Name: Reference#:
Requested By: DUKES DUKES KEATING AND FANECA	Fee Approval: Pages Sent: 10
Patient Name: MCBAY, GARY	
Date of Birth: 8/5/1976	
SSN: ***-**-4195	

Charge	Quantity	Rate	SubTotal	BaseFee	SearchFee	Tax	Shipping	CertMail	Total
Electronic Copy Fee	10	2.00	\$20.00	\$0.00	\$0.00	\$2.00	\$0.00	\$0.00	\$22.00
Affidavit Fee	1	25.00	\$25.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$25.00
		Totals:	\$45.00	\$0.00	\$0.00	\$0.00	\$2.00	\$0.00	\$47.00

The copy fee rate reflects the average rate for all items copied.

Pages 1 to 1 = \$20.00/pg

Pages 2 to 20 = \$0.00/pg

Pages 21 to 100 = \$1.00/pg

Pages 101+ = \$0.50/pg

MEMORIAL HOSPITAL AT GULFPORT has contracted with PHNS Inc - Hunter Account to provide medical information requested on GARY MCBAY. This request has been processed and the records are enclosed. We must receive your payment within 30 days of the invoice date. For questions regarding this invoice, call & phoneNumber & or write the address listed below. Checks returned for non-sufficient funds will be charged up to a \$0.00 fee.

Online Payment: Conveniently and securely pay your invoice online at www.huntermedicalsystems.com

Check: Please return a copy of this invoice with your payment and write the invoice number on your check. Make check payable to: PHNS Inc - Hunter Account, PO BOX 671281, Dallas, TX 75267-1281. Federal Tax I.D No. 72-1292247

Credit Card: Pay online or mail this section to the address listed above or fax to 214-257-7173

Invoice #:	Print Name:
Patient Name: GARY MCBAY	Address:
Amount to Total Charge: _____ Due: \$0.00	Address:
<input type="checkbox"/> Amex <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard <input type="checkbox"/> Discover	City, State, Zip:

Dukes, Dukes, Keating & Faneca, P.A.

WILLIAM F. DUKES
(1927 - 2003)

Walter W. Dukes
Hugh D. Keating
Cy Faneca
Phillip W. Jarrell *
W. Edward Hatten, Jr.
Trace D. McRaney
Bobby R. Long

Je'Nell B. Blum **
Haley N. Broom
Jon S. Tiner
Matthew M. Williams
Adam B. Harris

* ALSO LICENSED IN TX
** ALSO LICENSED IN CA

Dr. Larry Killebrew
Memorial Hospital
4500 13th St.
Gulfport, MS 39502-1810

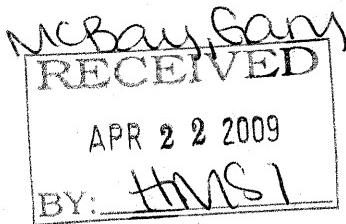
2909 13th Street, Sixth Floor
Gulfport, Mississippi 39501
Telephone: 228-868-1111
Facsimile: 228-863-2886
www.ddkf.com

Gulfport Mailing Address:
Post Office Drawer W
Gulfport, Mississippi 39502
Toll Free: (888) 542-2034



April 15, 2009

Hattiesburg Office:
100 Dudley W. Conner Street
Hattiesburg, Mississippi 39401
Telephone: 601-583-0999
Facsimile: 601-583-0997



Re: *Gary Brice McBay v. Harrison County Mississippi by and through its Board of supervisors; Harrison County Sheriff George Payne, in his official and individual capacity; Direct of Operations Major Wayne Payne, in his official and individual capacity; Director of Operations Major Wayne Payne, in his official and individual capacity; Director of Corrections Major Dianne Gaston Riley, in her official and individual capacity; Director of Professional Standards Unit Captain Steve Campbell, in his official and individual capacity; Supervisor of Booking Captain Rick Gaston, in his official and individual capacity; Corrections Officer Sergeant Ryan Teel, in his official and individual capacity; Corrections Officers John Doe 1-4 in their official and individual capacity; American Correctional Association and its Executive Director James A. Gondles, Jr. And employee(s) John and/or Jane Doe 1-3; Health Assurance LLC and its employee(s) John and/or Jane Doe 1-2*
Civil Action No. 1:07cv1205LG-JMR
Our File No. 1811.0119

To Whom It May Concern:

Our firm represents a defendant in a civil right lawsuit which has been filed by Gary Brice McBay.

Please forward to us all records you have reflecting Gary Brice McBay's treatment by you including, but not limited to, the following:

Copied By PHMS
Date _____
Rep _____
Dr. _____
DOS. _____

0531100375

- | | |
|---|--|
| 1. Questionnaires | 5. Surgical/Pathology Reports |
| 2. Histories | 6. All Hospital Records |
| 3. X-ray Reports | 7. Medical Reports and Summaries |
| 4. Office notes (handwritten and transcribed) | 8. Consultations |
| | 9. Any and all bills incurred for his/her care and treatment at your facility. |

Enclosed is a medical authorization form which complies with HIPAA.

Also enclosed is a Records Affidavit for your convenience in certification of these records. The Affidavit will need to be signed in front of a notary public for proper certification. Once the records have been obtained and the Affidavit has been executed, please forward same to me at the above listed address.

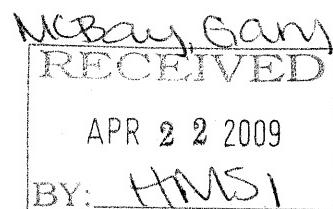
If there is a charge for this service, please forward a statement with the records; however, if the charge exceeds \$100, please contact me prior to processing this request.

Thank you in advance for your cooperation and attention in this matter.

Sincerely,

DUKES, DUKES, KEATING & FANECA, P.A.


Haley N. Broom



HNB/lc
Enclosures

cc: Michael Bruffey, Esquire

I hereby authorize Memorial Hospital to use or disclose the following protected health information (PHI) from the medical records of the patient listed below to:

Requestor Name: Dukes, Dukes, Keating and Faneca, P.A.
P.O. Drawer W
Gulfport, MS 39502

Patient Name: Gary Brice McBay
Patient DOB: August 5, 1976
Patient Social Security Number: 458-95-4195
Patient Address: c/o Michael Bruffey
496 Vieux Marche, Suite 1
Biloxi, MS 39533

OS31100375

McBay, Gary
RECEIVED
APR 22 2009
BY: HNS

Disclose the following PHI for treatment dates (08/05/76) to Present.

- | | | | |
|---|--|--|--|
| <input checked="" type="checkbox"/> Abstract/Pertinent | <input checked="" type="checkbox"/> History and Physical | <input checked="" type="checkbox"/> Physician Orders | <input checked="" type="checkbox"/> Entire Chart |
| <input checked="" type="checkbox"/> Operative Report | <input checked="" type="checkbox"/> Progress Notes | <input checked="" type="checkbox"/> X-ray | <input checked="" type="checkbox"/> Billing |
| <input checked="" type="checkbox"/> ER Report | <input checked="" type="checkbox"/> Lab | <input checked="" type="checkbox"/> Consult | |
| <input checked="" type="checkbox"/> Other specified | <input checked="" type="checkbox"/> Discharge Summary | <input checked="" type="checkbox"/> Nurse Notes | |
| <input checked="" type="checkbox"/> Other Specified: All other such records in your possession, custody or control. | | | |

The above information is disclosed for the following purposes:

- Medical Care Legal Insurance Personal Other

Gary I acknowledge, and hereby consent to such, that the release of information may contain alcohol initials and drug abuse, psychiatric, HIV or genetic information

This authorization shall expire upon this expiration date: final disposition of Gary Brice McBay or five (5) years from the date of this authorization, whichever comes first
**If I fail to specify an expiration date or event, this authorization will expire six (6) months from the date on which it was signed.

- I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to Memorial Hospital. I understand that the revocation will not apply to information that has already been released to this authorization.
- The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected.

I have read the above and authorize the disclosure of the protected health information as stated. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.

Gary Brice McBay
Signature of Patient/Legal Representative

4-16-09
Date

If signed by legal representative, relationship to patient: _____

Signature of Witness _____

Date _____

If signed by legal representative, relationship to patient: _____

Signature of Witness _____

Date _____

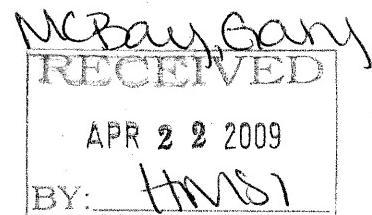
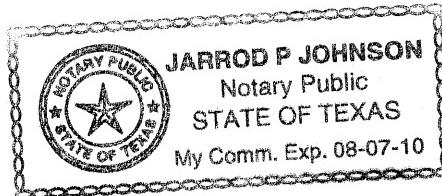
SWORN TO AND SUBSCRIBED BEFORE ME, this 6 day of April, 2009.

Jarrod P Johnson
NOTARY PUBLIC

My Commission Expires:

8-7-10

This authorization is designed to be in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") 45 CFR Parts 160 and 164.



F/C:S P/T:ERT

MCBAY, GARY B 05311-00375 11/07/05 11/07/05 1
 E R PHYSICIAN
 GARY BRICE MCBAY NO INSURANCE
 300 VZ COUNTY ROAD 3506
 EDGEWOOD TX 75117-3466 04/29/09

	CODE	DESCRIPTION	QTY
11/07	***250	PHARMACY	
	002834	TETANUS-DIPHTHERIA TOXOIDS-TD	1 49.90
		AREA TOTAL ***	49.90
11/07	***272	STERILE SUPPLY	
	013013	KIT URINE CULTURE CLEAN CATCH	1 48.50
		AREA TOTAL ***	48.50
11/07	***309	OTHER LABORATORY	
	075164	DRUG SCREEN-URINE RAPID (6 DRUGS)	1 500.60
		AREA TOTAL ***	500.60
11/07	***351	CT SCAN/HEAD	
	050017	CT BRAIN WITHOUT IV CONTRAST	1 1,693.50
11/07	050023	CT ORBIT/SELLA/P FOSSA/IAC W/O CX	1 1,693.50
		AREA TOTAL ***	3,387.00
11/07	***450	EMERGENCY ROOM	
	000100	INJECTION SQ/IM	1 33.60
11/07	060209	LEVEL VB-W DIAG TEST/PROCEDURE	1 1,008.10
		AREA TOTAL ***	1,041.70
11/07	***981	PROFESSIONAL FEES E/R	
	069321	E&M LEVEL III	1 230.40
		AREA TOTAL ***	230.40
		TOTAL CHARGES	5,258.10
		TOTAL PAYMENTS/ADJUSTMENTS	0.00
			5,258.10
			0.00
			5,258.10



E15 CP

MR 0000359017	PATIENT NAME MCBAY, GARY BRICE							ROOM NO. 05311-00375	ACCOUNT NO.
PATIENT ADDRESS 1109 SILVER CREEK		CITY DE SOTO							STATE ZIP CODE TX 75115
SOCIAL SECURITY NO 458-95-4195	ADMISSION DATE 11/07/05	ADM HOUR 1502	ADM TYPE 1	ADM SOURCE 7	ACCD CODE ERT	DISCHARGE DATE ER	MED SV.CD 999	ADM. PHY. 999	ATT. PHY. PHYSICIAN, E R
PATIENT PHONE (972) 223-2083	BIRTHDATE 08/05/76	AGE 29Y	SEX M	ORIGIN 4	MARITAL S	RELIGION UAF	CHURCH PREFERENCE UNAFFILIATED		
SPOUSE'S NAME MCBAY, GARY		NEAREST RELATIVE FATHER				RELATIONSHIP ADDRESS 1109 SILVER CREEK		CITY DE SOTO	
PRIMARY EMERGENCY PHONE (972) 223-2083	ALT. EMERGENCY PHONE	PATIENT EMPLOYER SELF							
ADDRESS OF EMPLOYER MCBAY, GARY BRICE		CITY				STATE	ZIP CODE	PHONE	
OTHER EMPLOYER SELF		ADDRESS				CITY	STATE	ZIP CODE	
GUARANTOR EMPLOYER ADDRESS OF GUARANTOR EMPLOYER		PHONE				GUARANTOR SOCIAL SECURITY NO. 458-95-4195			
ALTERCATION		ACCIDENT ALTERCATION W/ SHERIFF DE 11/06/05 2000							
NAME OF INSURANCE NO. 1		NAME OF INSURANCE NO. 2				NAME OF INSURANCE NO. 3			
GROUP NAME		GROUP NAME				GROUP NAME			
GROUP NO. / POLICYHOLDER		GROUP NO. / POLICYHOLDER				GROUP NO. / POLICYHOLDER			
STREET ADDRESS		STREET ADDRESS				STREET ADDRESS			
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE	
Admitting Diagnosis (Record here or on Physical Examination)									
Days									
PRINCIPAL Diagnosis									
Codes									
Complications and/or Additional Diagnosis (List All)									
Principal Procedure									
All Other Procedures									
PRINTED BY: slh9337									
DATE 5/19/2009									
Consultation with _____									
DISCHARGE STATUS <input type="checkbox"/> ALIVE <input type="checkbox"/> AMA <input type="checkbox"/> DIED <input type="checkbox"/> TRANSFER (AUTOPSY <input type="checkbox"/> YES <input type="checkbox"/> NO)									



140A

CONSENT FOR ADMISSION TO HOSPITAL AND MEDICAL TREATMENT

I, Gary Brice MCBay, give permission for such examination and treatment as the doctor(s) considers necessary or advisable for the care of MCBAY, GARY BRICE (Patient's Name).

I understand:

1. That examination and treatment may include x-rays, drawing blood, medical/surgical care, medicines, anesthesia, or other healing measures.
2. That unexpected situations may arise and I now give permission, in the event I am later unavailable or unable to consent, for the doctor(s) to do what is necessary to save the health, or life, of the above named patient.
3. If the above named patient deliver a baby during this hospital stay, I give permission for such examination and treatment of that baby as the doctor(s) considers necessary and advisable.
4. The practice of medicine and surgery is not an exact science. There are no guarantees of success.
5. I have read and do understand this consent. I have had a chance to ask questions. The MHG staff answered my questions.

OTHER TERMS OF ADMISSION

I understand:

1. Memorial Hospital at Gulfport will send me/the above named patient a bill.
2. Each physician specialist who examines or treats me or the above named patient will send a separate bill.
3. Physicians working in the Hospital Emergency Department are not employees of the hospital. They work for Emergency Care Specialists of Mississippi, Ltd., a separate organization which is an independent contractor to Memorial Hospital at Gulfport.
4. I am responsible for calling my Insurance company before admission. The insurance company may reduce my benefits if I do not follow procedures. The hospital will contact the insurance company only as a courtesy.
5. If I am in a Managed Care Plan requiring approval of a primary care physician (PCP), the hospital will contact the PCP for instructions. My insurer may not pay if I receive services without their approval. In this case, I may be personally responsible for all charges for these services.
6. Memorial Hospital will not deny or delay treatment for any emergency medical condition in order to contact or receive approval from my insurance company or any PCP.

WAIVER OF CLAIM FOR LOSS OR DAMAGE TO PERSONAL PROPERTY

I understand:

1. I may place my personal property in the Hospital safe.
2. I am responsible for loss of or damage to personal property that I do not place in the Hospital safe.

Wendy Hayd Date NOV 06 2005 Time 3:04 X Billie MCBay Date NOV 06 2005
Witness Signature of patient or person permitted to sign for patient

AUTHORIZATION TO RELEASE INFORMATION TO INSURER & ASSIGNMENT

I give permission to the Hospital to release medical information needed to process any claim related to this hospital stay against any of my insurance companies, including automobile or other liability insurance companies. MHG can release this medical information only to the insurance company or any third party payor involved in this claim. Third party payors may be Medicare, Medicaid, CHAMPUS, CHAMPVA, automobile or other liability insurance, or any worker compensation plan. This permission is good for the time provided in MHG's Health Information Management Department policy unless I deliver to the Hospital written notice of cancellation.

I assign all insurance benefits and all third party claims up to the amount owed to Memorial Hospital at Gulfport and to any physicians who provide services to me or the above named patient. I direct third party payors to pay all benefits directly to MHG and these physicians.

I have given current and correct information about my insurance or other benefit status to the Hospital.

W Hayd Date NOV 06 2005 X Billie MCBay Date NOV 06 2005
Witness Signature of patient or person permitted to sign for patient

FINANCIAL AGREEMENT AND GUARANTY OF PAYMENT

In consideration of services rendered the above named patient, I unconditionally guarantee payment for services not covered by insurance or a benefit program while a patient in Memorial Hospital at Gulfport. I guarantee this payment within 60 days of final billing. If I do not pay in full, within that time, MHG may refer the bill to an attorney or collection agency. If the bill is referred to an attorney, either by MHG or by a collection agency, I will be responsible for attorneys' fees of up to 33 1/3% in addition to the amount of the bill and legal interest from date 60 days after final billing. I understand that the Hospital has the right to examine credit bureau files for financial information on unpaid debts. MHG may inform any credit bureau of any hospital bill not paid within 60 days of final billing.

I have read and understand this financial agreement. I have had a chance to ask questions. The MHG staff answered my questions.

W Hayd Date NOV 06 2005 X Billie MCBay Date NOV 06 2005
Witness Signature of Patient or Guarantor of Account
Relationship to Patient

IF PATIENT IS UNABLE TO CONSENT TO THE FOREGOING OR IS A MINOR, COMPLETE THE FOLLOWING:

PATIENT IS A MINOR YEARS OF AGE / IS UNABLE TO CONSENT BECAUSE
Date / / Person Permitted to Sign for Patient Date / /
Witness

Important Message from Medicare received: _____ Signature of Patient _____ Clerk Initials _____ Date _____

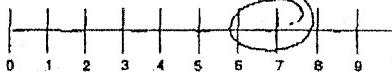
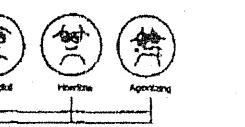
Memorial
Healthcare

**Consent for Admission
PRINTED BY: SIRH9337
DATE: 07/15/2009
to Hospital and
Medical Treatment**

PATIENT INFORMATION

ERT ERT -
MCBAY, GARY BRICE
11/07/2005 MR 0000359017
PHYSICIAN, E R
DOB 08/05/1976 0531100375
M 29Y



Name	<i>McBay G Brice</i>				DOB 8-5-96	Age 29																																																								
Triage Level	<input type="checkbox"/> Emergent Priority	<input checked="" type="checkbox"/> Urgent Priority	<input type="checkbox"/> Non-Urgent Priority	Emotional Status:		<input type="checkbox"/> Comatose <input type="checkbox"/> Anxious <input type="checkbox"/> Combative <input type="checkbox"/> Hostile <input type="checkbox"/> Calm <input type="checkbox"/> Cooperative <input type="checkbox"/> Other: <input type="checkbox"/> Adv. Directive <input type="checkbox"/> Living Will <input type="checkbox"/> DNR <input checked="" type="checkbox"/> NONE																																																								
<input type="checkbox"/> 24-72 Hour Return <input type="checkbox"/> Same Complaint <input checked="" type="checkbox"/> New Complaint <input type="checkbox"/> Call Back	On the Job Accident: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Date: _____ Time of Event: _____	Mode of Arrival: <input type="checkbox"/> W/C <input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Carried <input type="checkbox"/> Ambulance	Arrived With: <input type="checkbox"/> Friend <input type="checkbox"/> Self <input type="checkbox"/> Police <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input checked="" type="checkbox"/> Parent	Treatment Prior to Arrival: <input type="checkbox"/> None <input type="checkbox"/> Yes: <input type="checkbox"/> ice <input type="checkbox"/> IV <input type="checkbox"/> ACLS <input type="checkbox"/> O2 <input type="checkbox"/> Spine Board/C-Collar <input type="checkbox"/> Monitor <input type="checkbox"/> Splint/dressing <input type="checkbox"/> Other																																																										
Visual Acuity RT 20/ LT 20/ Both 20/	TET Tox <i>Untestable</i>	LMP <i>37</i>	Wt. <i>/</i>	Ht. <i>/</i>	TB Screen <input type="checkbox"/>	Persistent Cough > 2 weeks <input type="checkbox"/> Wt Loss <input type="checkbox"/> Hx of TB <input type="checkbox"/> Bloody Sputum <input type="checkbox"/> Fever <input type="checkbox"/> Night Sweats <input type="checkbox"/> Anorexia <input type="checkbox"/> No Symptoms <input type="checkbox"/> In Foreign Country Recently <input type="checkbox"/>																																																								
Date 11/9/05	Time 1442	Chief Complaint: (In Patient's Words) <i>State arrests last night - hit a post all day. Go to my car. Blurred to face abrasions. Blocked eyes</i>																																																												
RN Signature <i>[Signature]</i>		PAIN ASSESSMENT <input type="checkbox"/> None <input type="checkbox"/> Pt Uncooperative <input type="checkbox"/> Unable to assess due to acuity																																																												
Private Physician(s): <i>[Signature]</i>	<input type="checkbox"/> STAT (ED) Placement to Room # _____ Reported to _____ <input type="checkbox"/> To Lobby after triage - Awaiting Bed Availability <input type="checkbox"/> To Room # <i>775</i> at <i>1450</i> Report to _____ <input type="checkbox"/> LWBS at _____ <input type="checkbox"/> Refusal Obtained					Pain now: (circle) 																																																								
Social History: Lives - <input type="checkbox"/> Alone <input type="checkbox"/> N.H. <input checked="" type="checkbox"/> Family <input type="checkbox"/> Homeless Smoker - <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> PPD _____ ETOH Use - <input type="checkbox"/> Yes <input type="checkbox"/> No Abuse - <input type="checkbox"/> Yes <input type="checkbox"/> No	Past Surgical History: _____					For PEDS, use faces scale; document as 0-10. 																																																								
Past Medical History: <table border="1"><tr><td>Family</td><td>Patient</td><td>Family</td><td>Patient</td></tr><tr><td><input type="checkbox"/> Arthritis</td><td><input type="checkbox"/> Hypertension</td><td><input type="checkbox"/> ONBP</td><td><input type="checkbox"/> BP <i>144/90</i></td></tr><tr><td><input type="checkbox"/> Asthma</td><td><input type="checkbox"/> Lung Disease</td><td><input type="checkbox"/> Audible</td><td><input type="checkbox"/> 124-116</td></tr><tr><td><input type="checkbox"/> Cancer</td><td><input type="checkbox"/> COPD</td><td><input type="checkbox"/> Palpable</td><td><input type="checkbox"/> Pulse <i>124-116</i></td></tr><tr><td><input type="checkbox"/> CVA</td><td><input type="checkbox"/> Bronchitis</td><td><input type="checkbox"/> Nerves</td><td><input type="checkbox"/> Regular <input type="checkbox"/> Irregular</td></tr><tr><td><input type="checkbox"/> Diabetes</td><td><input type="checkbox"/> Back Problems</td><td><input type="checkbox"/> Seizures</td><td><input type="checkbox"/> Weak</td></tr><tr><td><input type="checkbox"/> GI</td><td><input type="checkbox"/> PVD</td><td><input type="checkbox"/> PVD</td><td><input type="checkbox"/> Resp <i>18</i></td></tr><tr><td><input type="checkbox"/> Ulcer</td><td><input type="checkbox"/> Mental</td><td><input type="checkbox"/> Mental</td><td><input type="checkbox"/> Regular <input type="checkbox"/> Shallow</td></tr><tr><td><input type="checkbox"/> Glaucoma</td><td><input type="checkbox"/> Renal</td><td><input type="checkbox"/> Renal</td><td><input type="checkbox"/> Shallow</td></tr><tr><td><input type="checkbox"/> Heart Disease</td><td><input type="checkbox"/> Thyroid</td><td><input type="checkbox"/> Thyroid</td><td><input type="checkbox"/> Laborated</td></tr><tr><td><input type="checkbox"/> Angina</td><td><input type="checkbox"/> None</td><td><input type="checkbox"/> None</td><td><input type="checkbox"/> Unresponsive</td></tr><tr><td><input type="checkbox"/> CAD</td><td></td><td></td><td><input type="checkbox"/> Disoriented</td></tr><tr><td><input type="checkbox"/> Hepatitis</td><td></td><td></td><td></td></tr><tr><td><input type="checkbox"/> HIV</td><td></td><td></td><td></td></tr></table> Comments: <i>chyphngia</i>	Family	Patient	Family	Patient	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hypertension	<input type="checkbox"/> ONBP	<input type="checkbox"/> BP <i>144/90</i>	<input type="checkbox"/> Asthma	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Audible	<input type="checkbox"/> 124-116	<input type="checkbox"/> Cancer	<input type="checkbox"/> COPD	<input type="checkbox"/> Palpable	<input type="checkbox"/> Pulse <i>124-116</i>	<input type="checkbox"/> CVA	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Nerves	<input type="checkbox"/> Regular <input type="checkbox"/> Irregular	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Back Problems	<input type="checkbox"/> Seizures	<input type="checkbox"/> Weak	<input type="checkbox"/> GI	<input type="checkbox"/> PVD	<input type="checkbox"/> PVD	<input type="checkbox"/> Resp <i>18</i>	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Mental	<input type="checkbox"/> Mental	<input type="checkbox"/> Regular <input type="checkbox"/> Shallow	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Renal	<input type="checkbox"/> Renal	<input type="checkbox"/> Shallow	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Laborated	<input type="checkbox"/> Angina	<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> Unresponsive	<input type="checkbox"/> CAD			<input type="checkbox"/> Disoriented	<input type="checkbox"/> Hepatitis				<input type="checkbox"/> HIV				Initial Vitals	BP <i>144/90</i> ONBP Audible Palpable Pulse <i>124-116</i> Regular <input type="checkbox"/> Irregular Weak Resp <i>18</i> Regular <input type="checkbox"/> Shallow Laborated Unresponsive Oral <input type="checkbox"/> Rectal Axillary SpO ₂ <input type="checkbox"/> Room Air 97% 0/2 at <i>1 L/MIN</i> Temperature <i>98</i> Skin Color <i>Normal Pink</i> Dark Pigment Cyanotic Pale Ashen Flushed Jaundiced Respiratory <i>Coherent</i> Incoherent Slurred Silent Speech Coherent Incoherent Slurred Silent Respiratory <i>Regular</i> Labored Shallow Retraactive Absent Skin <i>Normal</i> Moist Diaphoretic Pupils <i>N/A</i> Peri Unequal RT LT Skin Temp <i>Normal</i> Warm Hot Cool Patient Information <i>Cr brown</i> <i>crochets 1503</i> <i>old</i>				
Family	Patient	Family	Patient																																																											
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hypertension	<input type="checkbox"/> ONBP	<input type="checkbox"/> BP <i>144/90</i>																																																											
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<input type="checkbox"/> Hepatitis																																																														
<input type="checkbox"/> HIV																																																														
Special Needs or Physical Ability Needs <input type="checkbox"/> N/A <input type="checkbox"/> Blind Y/N Interpreter _____ <input type="checkbox"/> Foreign language Interpreter _____	<input type="checkbox"/> Teeth/Mouth problems _____ <input type="checkbox"/> Deaf Y/N Interpreter _____ <input type="checkbox"/> Financial <input type="checkbox"/> Emotional <input type="checkbox"/> Spiritual <input type="checkbox"/> Cultural																																																													

Memorial
Building a Healthier Community

Emergency Department
Nursing Record
PRINTED BY: aeq2177
DATE 11/8/2005

MCBAY, GARY BRICE

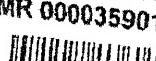
PHYSICIAN, E.R. 11/07/2005
MR 0000359017 DOB 08/05/1976

ERT M 29Y
0531100375

Patient Name _____ Account # _____ Date: _____

Ongoing Assessment Treatment

1433 P.C multiple bruises - blackened eyes L & R Lt
happened early AM at Police Station - nose
is not straight abrasion across it forehead
abrasion. Lt forehead elbow minor knee
Contusions - Dr Rillekens to see pt P.D.
1510 CTG & Joliet sed-brain ordered - drs available
1535 pt to CTG R&H EPT, 1555 pt to Rom from CT H.H. EPT 1732, 1745 pt failed
delivered to lab Skokie (in care of) family to
arr. tomorrow for results - pt off x 3 fully
ambulatory. No acute or raised

Time	Medication	Dose	Mode	Site	Signature	Time	Medication	Dose	Mode	Site	Signature	
1500	dt 6.5cc	IM		<i>Stacy Lynn</i>								
LOT U15960A EXPIRE 08-10 1000 mg vial 15 mL	5057	LOT U15960A EXP 18APR07										
MCBAY,GARY BRICE PHYSICIAN,E R MR 0000359017  11/07/2005 DOB 08/05/1976 ERT M 29Y 0531100375												
I N F U S I O N	Amt	Solution	Additive	Device	Site	Rate	Start	Stop	Total Amount	Signature	Intake	Output
Disposition <i>1732 AM/PM</i>	<input type="checkbox"/> Admitted Time	Room No.	Ready Room Time	<input checked="" type="checkbox"/> Discharged via	<input checked="" type="checkbox"/> Ambulatory	<input type="checkbox"/> Wheelchair						
				<input type="checkbox"/> In Arms	<input type="checkbox"/> Ambulance							

PRINTED BY: aeq2177

DATE 11/8/2005

9753 (Page 2 of 2) (4/05)

HISTORY AND PHYSICAL		Time:	FMH:	SH:	4000A	
CC/PHI:					ROS:	* if neg.
<p>24yo male in alteration E pedic last pm - Derm chest, arms, face</p> <p>PE Lungs clear cv RSR No intact</p> <p>Bruising over arms bilaterally - Bruising chest large (2) periorbital hemorrhage Bruising under (2) eye</p>					Gen:	0
					Card:	0
					Resp:	0
					Renal:	0
					End:	0
					GI:	0
					Neuro:	0
					Eye:	0
					ENT:	0
					Skin:	0
					Psych:	0
					Ms/Stl:	0
ORDERS						
			Test Order	Tim/int.		
			CT brain	3		
			CT orbits	3		
			APUDS			
LAB:			X-RAY		Nurse Order	Tim/int.
			EKG		106.5cc (141ml)	
			U.S./C.T.			
DIAGNOSIS:		Nasal fracture				
<input type="checkbox"/> May Discharge	<input type="checkbox"/> Transfer	Condition on Discharge	I HAVE REVIEWED THE NURSES ASSESSMENT AND HISTORY		<input type="checkbox"/> See Dictated Notes	
<input type="checkbox"/> Admit	<input type="checkbox"/> AMA	<input checked="" type="checkbox"/> Stable	Physician's Signature <i>KC</i>			
Patient Instructions						
<input type="checkbox"/> Sprain & Fracture, Severe Bruises <input type="checkbox"/> Medications <input type="checkbox"/> Head Inj (adult) <input type="checkbox"/> Fever <input type="checkbox"/> Back/Neck Inj <input type="checkbox"/> Vomiting/Diarrhea <input type="checkbox"/> Common Cold/Viruses <input type="checkbox"/> Sedation Instruction <input type="checkbox"/> Reducing High Fever <input type="checkbox"/> Orthopedic Appliance <input type="checkbox"/> Head Inj (Child) <input type="checkbox"/> Eye Inj <input type="checkbox"/> Wound Care/Animal Bite <input type="checkbox"/> Burns <input type="checkbox"/> Other						
DISCHARGE INSTRUCTIONS:						
<i>Take meds as ordered return as needed</i>						
Follow Up	<input type="checkbox"/> Make an appointment to see your regular physician		<input type="checkbox"/> Follow-up Visit in Emergency Department		<input type="checkbox"/> Have Sutures Removed in Days	
PATIENT/SO VERBALIZED UNDERSTANDING OF INSTRUCTIONS			I HAVE READ AND UNDERSTAND AND INSTRUCTIONS AND HAVE RECEIVED A COPY OF THEM			
Nurse Signature <i>Gary Brice</i>			Patient Signature <i>Gary Brice</i>			
PATIENT INFORMATION						
MCBAY, GARY BRICE PHYSICIAN, ER MR 0000359017 11/07/2005 PRINTED BY: seq2177 DOB 08/05/1976 DATE 11/8/2005 ERT M 29Y  0531100375						
Memorial Building a Healthier Community						

MCBAY, GARY BRICE
MR# G0000359017
SERV: ERT
PT TYPE: ERT LOC: ERT
ORD: KILLEBREW, LARRY MD
ATT: PHYSICIAN, E R MD

DOB: 08/05/76 AGE: 29Y
CI# 834729 ACCOUNT # 0531100375

EXAM DATE: 11/07/05
ADM: PHYSICIAN, E R MD

Chk-in #	Order	Exam
834729	0001	50017 CT BRAIN WITHOUT IV CONTRAST Ord Diag: trauma

CT BRAIN WITHOUT IV CONTRAST:

CLINICAL HISTORY PROVIDED: Altercation with head trauma.

Multiple sequential sections were obtained through the brain and there is a large left temporoparietal scalp hematoma. There is no associated fracture.

Brain attenuation is normal with no focal ischemic infarct, mass, or hemorrhage. Ventricular system is normal and midline structures are midline. There is no acute extraaxial fluid accumulation.

There is some mucosal thickening of the ethmoid air cells bilaterally.

IMPRESSION:

THERE IS A RELATIVELY LARGE LEFT TEMPOROPARIETAL SCALP HEMATOMA OR CONTUSION. THERE IS NO ASSOCIATED FRACTURE OR ACUTE INTRACRANIAL ABNORMALITY.

THERE IS SOME MUCOSAL THICKENING OF THE ETHMOID AIR CELLS BILATERALLY.

/Read By/ MILTON R RAINES, M.D.
/Released By/ MILTON R RAINES, M.D.
Typed By: SKY
Typed On: 11/07/05 1647

11/07/05 2016 PRELIMINARY UNLESS RELEASED

DRS. BARRETT, JUSTICE, TIPTON, DIAZ, MASSONY, LOVELL, RAINES, COREY,
LAWSON, STOREY, RADIOLOGISTS
FINAL

Page :1

RADIOLOGY REPORT

PRINTED BY: aeq2177
DATE 11/8/2005

RADIOLOGY REPORT

MCBAY, GARY BRICE
MR# G0000359017
SERV: ERT
PT TYPE: ERT LOC: ERT
ORD: KILLEBREW, LARRY MD
ATT: PHYSICIAN, E R MD

DOB: 08/05/76 AGE: 29Y
CI# 834748 ACCOUNT # 0531100375

EXAM DATE: 11/07/05
ADM: PHYSICIAN, E R MD

Chk-in #	Order	Exam
834748	0003	50023 CT ORBIT/SELLA/P FOSSA/IAC W/O CX Ord Diag: ALTERCATION

CT OF THE ORBITS:

CLINICAL HISTORY PROVIDED: Altercation. Orbital injury.

Multiple sequential sections were obtained through the orbits and there is comminuted nasal bone fracture with deviation of the nasal septum to the right posteriorly with spurring which is chronic in appearance. I do not see a definite orbital fracture. There is mucosal thickening ethmoid air cells bilaterally and frontal sinuses more on right than left. There is also air within the soft tissues over the anterior and lateral right maxillary sinus although no definite orbital floor or sinus fractures are seen. There is soft tissue swelling over the orbits and face bilaterally.

IMPRESSION:

COMMUNITED NASAL BONE FRACTURE. MUCOSAL THICKENING BILATERAL ETHMOID AND FRONTAL SINUSES WHICH IS MORE PROMINENT ON RIGHT THAN THE LEFT, PROBABLY RELATED TO TRAUMA AND MILD BLEEDING. SOFT TISSUE AIR OVER THE RIGHT MAXILLARY SINUS BUT NO DEFINITE ORBITAL OR MAXILLARY FRACTURE IS IDENTIFIED. PROMINENT DEVIATION OF THE NASAL SEPTUM APPEARS CHRONIC.

/Read By/ MILTON R RAINES, M.D.
/Released By/ MILTON R RAINES, M.D.
11/07/05 2016
Typed By: SKY
Typed On: 11/07/05 1650

PRELIMINARY UNLESS RELEASED

DRS. BARRETT, JUSTICE, TIPTON, DIAZ, MASSONY, LOVELL, RAINES, COREY,
LAWSON, STOREY, RADIOLOGISTS
FINAL

Page : 1

RADIOLOGY REPORT

PRINTED BY: aeq2177
DATE 11/8/2005

***** MHG PATIENT INQUIRY Demand Report *****

Patient: MCBAY, GARY BRICE
 Age: 29Y Sex: M DOB:08/05/76
 MR#: 0000359017
 Admit Phys: PHYSICIAN, E R DE
 Attend Phys: KILLEBREW, LARRY MD

Loc: ERT

Facility: ER Trauma

** PI DEMAND REPORT **

Admit#: 0531100375

Order Phys: KILLEBREW, LARRY MD

RunID: R1621536

Consult Phys:

Reported: 11/08/05 10:19

***** TOXICOLOGY *****

		REF RANGE	UNITS
	11/07/05		
	17:30		
Amphet	Negative		
Barb	Negative		Negative
Benzo	Negative		Negative
Cannab	Negative		Negative
Cocaine	Negative		Negative
Opiate	Negative		Negative
Comment	See Note ¹		Negative

¹ Results are for medical / screening purposes only. Confirmation testing by reference lab available if ordered within 48 hours

Patient: MCBAY, GARY BRICE

Page 1 of 1

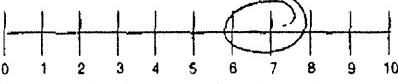
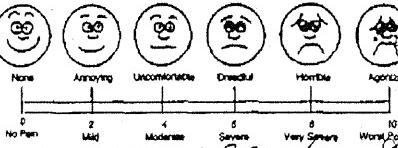
Clinical / Pathology Laboratory * Memorial Hospital at Gulfport * 4500 13th Street * Gulfport, MS 39501
 Phone: 228-575-2300 * Fax: 228-575-2387

MHG Dept. of Pathology: P. Saccoccia, Jr., MD C. Slonaker, MD M.J. Gandour, MD J. Causey, MD

***** TOXICOLOGY *****



1720C

Name	<i>McBay G Brice</i>					DOB	8-5-96	Age	29
Triage Level	<input type="checkbox"/> Emergent Priority	<input checked="" type="checkbox"/> Urgent Priority	<input type="checkbox"/> Non-Urgent Priority	Emotional Status:		<input type="checkbox"/> Comalose	<input checked="" type="checkbox"/> Calm	<input type="checkbox"/> Adv. Directive	
				<input type="checkbox"/> Anxious	<input type="checkbox"/> Combative	<input checked="" type="checkbox"/> Cooperative	<input type="checkbox"/> Living Will		
				<input type="checkbox"/> Hostile	<input type="checkbox"/> Other:		<input type="checkbox"/> DNR	<input checked="" type="checkbox"/> NONE	
<input type="checkbox"/> 24-72 Hour Return <input type="checkbox"/> Same Complaint <input checked="" type="checkbox"/> New Complaint <input type="checkbox"/> Call Back		On the Job Accident: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Date: _____ Time of Event: _____		Mode of Arrival: <input type="checkbox"/> W/C <input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Carried <input type="checkbox"/> Ambulance		Arrived With: <input type="checkbox"/> Friend <input type="checkbox"/> Self <input type="checkbox"/> Police <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input checked="" type="checkbox"/> Parent		Treatment Prior to Arrival: <input type="checkbox"/> None <input type="checkbox"/> Yes: <input type="checkbox"/> ice <input type="checkbox"/> IV <input type="checkbox"/> ACLS <input type="checkbox"/> O2 <input type="checkbox"/> Spine Board/C-Collar <input type="checkbox"/> Monitor <input type="checkbox"/> Splint/dressing <input type="checkbox"/> Other	
Visual Acuity RT 20/ LT 20/ Both 20/		TET Tox _____ LMP <i>3</i> Actual <input checked="" type="checkbox"/>		Wt.	Ht.	TB Screen <input type="checkbox"/> Persistent Cough > 2 weeks <input type="checkbox"/> Wt Loss <input type="checkbox"/> Hx of TB <input type="checkbox"/> Bloody Sputum <input type="checkbox"/> Fever <input type="checkbox"/> Night Sweats <input type="checkbox"/> Anorexia <input checked="" type="checkbox"/> No Symptoms <input type="checkbox"/> In Foreign Country Recently			
Date	Time	Chief Complaint: (In Patient's Words) <i>State awakes last night hit in foot all</i> <i>over body to go bad pain. Unable to face</i> <i>exposure. Blurred eyes</i>							
		PAIN ASSESSMENT <input type="checkbox"/> None <input type="checkbox"/> Pt Uncooperative <input type="checkbox"/> Unable to assess due to acuity							
		Pain now: (circle)  For PEDS, use faces scale; document as 0-10. 							
Private Physician(s): <i>APM</i>		<input type="checkbox"/> STAT (ED) Placement to Room # _____ Reported to _____ <input type="checkbox"/> To Lobby after triage - Awaiting Bed Availability <input type="checkbox"/> To Room # <i>775</i> at <i>1450</i> Report to _____ <input type="checkbox"/> LWBS at _____ <input type="checkbox"/> Refusal Obtained							
Social History: Lives - <input type="checkbox"/> Alone <input type="checkbox"/> N.H. <input checked="" type="checkbox"/> Family <input type="checkbox"/> Homeless Smoker - <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> PPD _____ ETOH Use - <input type="checkbox"/> Yes <input type="checkbox"/> No Abuse - <input type="checkbox"/> Yes <input type="checkbox"/> No		Past Surgical History: _____							
Past Medical History: Family _____ Patient _____ <input type="checkbox"/> Arthritis <input type="checkbox"/> Hypertension <input type="checkbox"/> Asthma <input type="checkbox"/> Lung Disease <input type="checkbox"/> Cancer <input type="checkbox"/> COPD <input type="checkbox"/> CVA <input type="checkbox"/> Bronchitis <input type="checkbox"/> Diabetes <input type="checkbox"/> Nerves <input type="checkbox"/> GI <input type="checkbox"/> Back Problems <input type="checkbox"/> Ulcer <input type="checkbox"/> Seizures <input type="checkbox"/> Glaucoma <input type="checkbox"/> PVD <input type="checkbox"/> Heart Disease <input type="checkbox"/> Mental <input type="checkbox"/> Angina <input type="checkbox"/> Renal <input type="checkbox"/> CAD <input type="checkbox"/> Thyroid <input type="checkbox"/> Hepatitis <input type="checkbox"/> None <input type="checkbox"/> HIV		Initial Vitals BP <i>124/92</i> <input type="checkbox"/> NIBP <input type="checkbox"/> Audible <input type="checkbox"/> Palpable Pulse <i>124-116</i> <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Weak Resp <i>18</i> <input type="checkbox"/> Regular <input type="checkbox"/> Shallow <input type="checkbox"/> Labored Temperature <i>98</i> <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Axillary SpO ₂ : <input type="checkbox"/> Room Air <input type="checkbox"/> 0/2 at _____ L/MIN <i>99%</i>							
Comments: <i>dry cough</i> <i>fx none on meds</i>		ALLERGIES <input type="checkbox"/> NONE KNOWN Food, Medication, Latex, Tape, Iodine, Other _____ 1. <i>My cat powder</i> 2. <i>powder</i> 3.							
		Mental Status <input type="checkbox"/> Alert <input type="checkbox"/> Uncooperative <input checked="" type="checkbox"/> Coherent <input checked="" type="checkbox"/> Oriented X 3 <input type="checkbox"/> Combative <input type="checkbox"/> Incoherent <input type="checkbox"/> Lethargic <input type="checkbox"/> Drowsy <input type="checkbox"/> Slurred <input type="checkbox"/> Unresponsive <input type="checkbox"/> Disoriented <input type="checkbox"/> Silent Speech <input type="checkbox"/> Coherent <input type="checkbox"/> Incoherent <input type="checkbox"/> Incoherent <input type="checkbox"/> Drowsy <input type="checkbox"/> Slurred <input type="checkbox"/> Disoriented <input type="checkbox"/> Silent							
		Respiratory <input type="checkbox"/> Regular <input type="checkbox"/> Laboring <input type="checkbox"/> Shallow <input type="checkbox"/> Retractions <input type="checkbox"/> Absent							
		Skin Color <input type="checkbox"/> Normal Pink <input type="checkbox"/> Ashen <input type="checkbox"/> Dark Pigment <input type="checkbox"/> Flushed <input type="checkbox"/> Cyanotic <input type="checkbox"/> Jaundiced <input type="checkbox"/> Pale							
		Pupils <input type="checkbox"/> N/A <input checked="" type="checkbox"/> Peri							
		Skin Temp <input type="checkbox"/> Warm <input type="checkbox"/> Hot <input type="checkbox"/> Cool							
		PATIENT INFORMATION <i>J.C. Brown</i> <i>Crookets 1503</i> <i>do</i>							
Memorial <i>Bethany Health Community</i>		Emergency Department Nursing Record PRINTED BY: <i>sLh9337</i> DATE: <i>5/19/2009</i>							
		MCBAY, GARY BRICE PHYSICIAN, E.R. <i>11/07/2005</i> MR 0000359017 DOB 08/05/1976 ERT M 29Y 0531100375							

Patient Name _____ Account # _____ Date: _____

Ongoing Assessment Treatment

1453 PT multiple bruises - blackened eyes L & R t
happened early AM at Police Station - nose
is not straight abrasion across it forehead
abrasion. Lt forehead elbow minor knee
Contusions - by Killebrew you see pt per
1510 CTG Forked brain ordered - as follows
1535 PT CTG AMP 71 EDT, 1555 PT Rm from CT 87 EDT (732) Tiffs of blood
delivered to lab (I know you care) family to
get tomorrow for results - pt still x 3 fully
ambulatory. No cause to release pt

PRINTED BY: slh9337

DATE 5/19/2009

HISTORY AND PHYSICAL		Time: _____	FMH: _____	SH: _____	 *4000A*
<p>29yo involved in altercation w/ police last pm - Dm chest, arms, face</p> <p>PE Lungs clear cv RSV N/V intact Bruising over arms bilaterally - Bruising chest large (l) periorbital hematoma Bruising under R eye</p>		ROS: <input checked="" type="checkbox"/> if neg. Gen: <input type="checkbox"/> Card: <input type="checkbox"/> Resp: <input type="checkbox"/> Renal: <input type="checkbox"/> End: <input type="checkbox"/> GI: <input type="checkbox"/> Neuro: <input type="checkbox"/> Eye: <input type="checkbox"/> ENT: <input type="checkbox"/> Skin: <input type="checkbox"/> Psych: <input type="checkbox"/> Ms/Stl: <input type="checkbox"/>			
ORDERS					
		Test Order	Tm/Int.		
		ct mri/s	ct orbits		
		U/S			
LAB:		X-RAY	Nurse Order	Tm/Int.	
		EKG	166.5cc 1M now		
		U.S./C.T.			
DIAGNOSIS: Nasal fracture					
<input checked="" type="checkbox"/> May Discharge <input type="checkbox"/> Admit Time 1832		<input type="checkbox"/> Transfer <input type="checkbox"/> AMA <input checked="" type="checkbox"/> Condition on Discharge <input checked="" type="checkbox"/> Stable	I HAVE REVIEWED THE NURSES ASSESSMENT AND HISTORY <input type="checkbox"/> See Dictated Notes Physician's Signature 		
Patient Instructions <input type="checkbox"/> Sprain & Fracture, Severe Bruises <input type="checkbox"/> Medications <input type="checkbox"/> Head Inj (adult) <input type="checkbox"/> Fever <input type="checkbox"/> Back/Neck Inj <input type="checkbox"/> Vomiting/Diarrhea <input type="checkbox"/> Common Cold/Viruses <input type="checkbox"/> Sedation Instruction <input type="checkbox"/> Reducing High Fever <input type="checkbox"/> Orthopedic Appliance <input type="checkbox"/> Head Inj (Child) <input type="checkbox"/> Eye Inj <input type="checkbox"/> Wound Care/Animal Bite <input type="checkbox"/> Burns <input type="checkbox"/> Other					
DISCHARGE INSTRUCTIONS: <i>Ice meds as ordered return as needed</i>					
Follow Up		<input type="checkbox"/> Make an appointment to see your regular physician	<input type="checkbox"/> Follow-up Visit in Emergency Department	<input type="checkbox"/> Have Sutures Removed in Days	
PATIENT/SO VERBALIZED UNDERSTANDING OF INSTRUCTIONS <i>Gary</i> Nurse Signature			I HAVE READ AND UNDERSTAND AND INSTRUCTIONS AND HAVE RECEIVED A COPY OF THEM Patient Signature <i>R. Brice M.Bay</i>		

Memorial
Building a Healthier Community

Emergency
Department
Physician
Record
PRINTED BY: slb9337
DATE: 5/19/2009

MCBAY, GARY BRICE
PHYSICIAN, E.R.
MR 0000359017



11/07/2005
DOB 08/05/1976
ERT M 29Y
0531100375

***** MHG Cumulative Summary Report *****

Patient: MCBAY, GARY BRICE
 Age: 29Y Sex: M
 DOB: 08/05/76
 MR#: 0000359017
 Admit Phys: PHYSICIAN, E R DE
 Attend Phys: KILLEBREW, LARRY MD

Admit Loc: ERT
 Facility: ER Trauma
 Admit#: 0531100375
 Order Phys: KILLEBREW, LARRY MD
 Consult Phys:

** MEDICALR DISCHARGE REPORT **
 *** PERMANENT REPORT - DO NOT DISCARD ***
 Dsch Date: 11/07/05
 RunID: R1624489
 Reported: 11/10/05 03:11

***** TOXICOLOGY *****

		REF RANGE	UNITS
	11/07/05		
	17:30		
Amphet	Negative		Negative
Barb	Negative		Negative
Benzo	Negative		Negative
Cannab	Negative		Negative
Cocaine	Negative		Negative
Opiate	Negative		Negative
Comment	See Note ¹		

¹Results are for medical / screening purposes only. Confirmation testing by reference lab available if ordered within 48 hours..

Patient: MCBAY, GARY BRICE

Page 1 of 1

Clinical / Pathology Laboratory * Memorial Hospital at Gulfport * 4500 13th Street * Gulfport, MS 39501
 Phone: 228-575-2300 * Fax: 228-575-2387

MHG Dept. of Pathology: P. Saccoccia, Jr., MD C. Slonaker, MD M.J. Gandour, MD J. Causey, MD
 PRINTED BY: slh9337

***** TOXICOLOGY *****

MCBAY, GARY BRICE DOB: 08/05/76 AGE: 29Y
MR# G0000359017 CI# 834729 ACCOUNT # 0531100375
SERV: ERT
PT TYPE: ERT LOC: ERT EXAM DATE: 11/07/05
ORD: KILLEBREW, LARRY MD ADM: PHYSICIAN, E R MD
ATT: PHYSICIAN, E R MD

Chk-in # Order Exam
834729 0001 50017 CT BRAIN WITHOUT IV CONTRAST
Ord Diaq: trauma

CT BRAIN WITHOUT IV CONTRAST:

CLINICAL HISTORY PROVIDED: Altercation with head trauma.

Multiple sequential sections were obtained through the brain and there is a large left temporoparietal scalp hematoma. There is no associated fracture.

Brain attenuation is normal with no focal ischemic infarct, mass, or hemorrhage. Ventricular system is normal and midline structures are midline. There is no acute extraaxial fluid accumulation.

There is some mucosal thickening of the ethmoid air cells bilaterally.

IMPRESSION:

THERE IS A RELATIVELY LARGE LEFT TEMPOROPARIETAL SCALP HEMATOMA OR
CONTUSION. THERE IS NO ASSOCIATED FRACTURE OR ACUTE INTRACRANIAL
ABNORMALITY.

THERE IS SOME MUCOSAL THICKENING OF THE ETHMOID AIR CELLS BILATERALLY.

/Read By/ MILTON R RAINES, M.D.

/Released By/ MILTON R RAINES, M.D.
11/07/05 2016

PRELIMINARY UNLESS RELEASED

Typed By: SKY

Typed On: 11/07/05 1647

DRS. BARRETT, JUSTICE, TIPTON, DIAZ, MASSONY, LOVELL, RAINES, COREY,
LAWSON, STOREY, RADIOLOGISTS
FINAL Page : 1

Page : 1

RADIOLOGY REPORT

PRINTED BY: slh9337
DATE 5/19/2009

MCBAY, GARY BRICE

MR# G0000359017

DOB: 08/05/76

AGE: 29Y

CI# 834748 ACCOUNT # 0531100375

SERV: ERT

PT TYPE: ERT LOC: ERT

EXAM DATE: 11/07/05

ORD: KILLEBREW, LARRY MD

ADM: PHYSICIAN, E R MD

ATT: PHYSICIAN, E R MD

Chk-in #	Order	Exam
834748	0003	50023 CT ORBIT/SELLA/P FOSSA/IAC W/O CX Ord Diag: ALTERCATION

CT OF THE ORBITS:

CLINICAL HISTORY PROVIDED: Altercation. Orbital injury.

Multiple sequential sections were obtained through the orbits and there is comminuted nasal bone fracture with deviation of the nasal septum to the right posteriorly with spurring which is chronic in appearance. I do not see a definite orbital fracture. There is mucosal thickening ethmoid air cells bilaterally and frontal sinuses more on right than left. There is also air within the soft tissues over the anterior and lateral right maxillary sinus although no definite orbital floor or sinus fractures are seen. There is soft tissue swelling over the orbits and face bilaterally.

IMPRESSION:

COMMUNITED NASAL BONE FRACTURE. MUCOSAL THICKENING BILATERAL ETHMOID AND FRONTAL SINUSES WHICH IS MORE PROMINENT ON RIGHT THAN THE LEFT, PROBABLY RELATED TO TRAUMA AND MILD BLEEDING. SOFT TISSUE AIR OVER THE RIGHT MAXILLARY SINUS BUT NO DEFINITE ORBITAL OR MAXILLARY FRACTURE IS IDENTIFIED. PROMINENT DEVIATION OF THE NASAL SEPTUM APPEARS CHRONIC.

/Read By/ MILTON R RAINES, M.D.

/Released By/ MILTON R RAINES, M.D.
11/07/05 2016

PRELIMINARY UNLESS RELEASED

Typed By: SKY

Typed On: 11/07/05 1650

DRS. BARRETT, JUSTICE, TIPTON, DIAZ, MASSONY, LOVELL, RAINES, COREY,
LAWSON, STOREY, RADIOLOGISTS
FINAL

Page :1

RADIOLOGY REPORT

PRINTED BY: slh9337

DATE 5/19/2009



INTERDISCIPLINARY PATIENT/FAMILY EDUCATION FLOW SHEET

DOCUMENTATION LEGEND:

Topic									
M - Medications E - Equipment	P - Procedure C - Consents	D - Diet DX - Diagnosis	A - ADL T - Treatment	FDI - Food/Drug Interaction Other _____					
Readiness to Learn:									
Ability to Understand Verbal Instruction:	VP - Poor	VA - Average	VG - Good						
Cognitively Able to Understand:	CP - Poor	CA - Average	CG - Good						
Ability to Understand Written Instruction:	WP - Poor	WA - Average	WG - Good						
Barriers to Learning:									
P - Physical	V - Visual	C - Cognitive	M - Motivation	R - Religious					
R - Reading	L - Language	CL - Cultural	AR - Age Related	E - Emotional					
A - Auditory	N - None								
Who:									
PT - Patient	F - Family	O - Other							
Learning Method Used:									
D - Demonstration	TV - Video/TV/Audio	W - Written	GR - Group Work						
P - Pamphlet	V - Verbal Instruction	MED - Medication Instruction Sheet	O - Other						
Comprehension:									
1. Verbalized or demonstrated understanding.	4. Medical condition limits understanding.								
2. Not receptive/cooperative.	5. _____								
3. Needs further instruction.	6. _____								
DATE/ TIME	PROVIDER INITIAL	TOPIC	READINESS TO LEARN	BARRIERS TO LEARNING	WHO	LEARNING METHOD USED	COMPREHENSION	PREFERRED LEARNING METHOD: _____	
11/3/05 1740	JG	MR	VB	w to	Uw	1		INFORMATION TAUGHT Medication education at study preceptor- from info as directed Hello AT JG	



**Interdisciplinary
Patient/Family
Education Flow sheet**

PATIENT INFORMATION

ERT ERT -
MCBAY, GARY BRICE
11/07/2005 MR 0000359017
PHYSICIAN, E R
DOB 08/05/1976 0531100375
M 29Y

